Working Group for Healthcare Innovation
Meeting #2
Wednesday October 7, 2015 – 4:00pm
Meeting Minutes

I. **Welcome from Secretary Roberts**

Secretary Roberts welcomed the group, and advised that today's initial focus is on the Total Cost of Care Work.

The Secretary gives a brief update from a process perspective. Presentation slides available on the website and upon request via email at lauren.lapolla@ohhs.ri.gov.

No questions were asked by the group following this initial presentation and the Secretary introduced Commissioner Hittner to come forward for the next portion of the meeting.

II. **Presentation on Rhode Island's Total Cost of Care by Health Insurance Commissioner Kathleen Hittner, MD & Wakely Consultants**

Commissioner Hittner began the presentation with an overview, and then turned it over to the Wakely Consultants who conducted the Total Cost of Care Study. The presentation slides from both presenters are available on the website and upon request via email at lauren.lapolla@ohhs.ri.gov.

III. **Working Group Discussion**

The floor was opened for the Working Group to interact with the Wakely Consultants and discuss the presentation just given.

Q. As a part of the work here, will there be forecasting?
A. No just looking backwards, forecasting wasn't part of the scope. On the Pharmacy side there may be information which would lead to well informed decisions on the forecasting.

Dennis Keefe: Excellent presentation. The '14, 1'5 trends have been holding, the data seems correct. For '15 we will see a bump because of the ACA.

Pablo Rodriguez: The ACA is bringing in other things to this analysis, as the EMRs are also bringing in a new area to this analysis. I am a gynecologist, and have been using EPIC as a part of this. Everyone has been flagged down to ensure they are getting their appropriate mammograms, pap smears etc., and we are already increasing the

utilization of screening tests. The more we look, the more we will find. We need to not just look at cost, but look at quality. I don't know how you can account for this transformation when the majority of providers in the state are going to be under the EPIC system which will flag you to do all the tests. How to claim success as utilization goes up in an attempt to watch costs?

Wakely: I think it has to do with where the utilization is happening, and where it is going up, need to put it in context. You are right the more you screen the more you catch, but hopefully with the use of EMR there is less duplication of services and efficiency there.

Ted Almon: I am curious why using insurers' medical costs instead of premium? If we undertook the job you have as a business we would use cost accounting, separate into those that add value to the product (patient care) and then administrative cost. To look at administrative cost seems out of the box for the state.
Wakely (Steve): We looked mostly at medical costs, claim costs, so to that end I cannot comment further.

James Raiola: As many employers will be moving into the ACA mandate, the numbers may go down as we head into 2016. Second comment, those trends are very encouraging. For large companies their rates are largely above general inflation and that is what your numbers are for. There is a large number who have been categorized as small group, and will not be able to. There was a law just passed to allow states to consider businesses of 50-99 to remain small group, and we need to take a look at that. We would love to have it remained and categorized as 50-99
Dr. Hittner: We know this is a huge issue and actually we have been working very hard studying what went before the General Assembly to understand all the reasoning there, reviewing the literature and what is going on in other states. Also speaking with our actuaries to determine what they see as the consequences of this in RI, and other states. We have a big meeting tomorrow to discuss this to see what is best for RI.

Sam Salganik: Follow up question -I see a lot of information about dollars but not a lot about value. I am sensitive to thinking about what we are getting for what we are paying.
Wakely: I think that takes a clinical medical slant that we have not studied here, but perhaps Dr. Hittner can speak to it further. I have seen severity in an emergency room utilized to allude to if the number of emergency room visits are not severe, perhaps that would lead to opening more urgent care and primary care centers.

Dr. Hittner: These are great questions and we don't want to sacrifice quality of care. As we have all these tests, we take them, then we know

about them. Yes, will see utilization go up, good point. Hopefully by doing that we have less expensive utilization at the other end to treat things that may have been missed or out of control. We are not just looking at cost, we have a whole committee that is looking at the harmonization of measures that we will use to measure the quality and that is very important to us. OHIC is working on care transformation, and on value. We do not intend to sacrifice value for cost. We believe there is a lot in the system that can be taken out and the system improved. When the Governor asked me what was one thing I would want to work on and improve I said pharmacy. We are looking at the numbers on that.

Ted Almon: Moving procedures in general out of the hospital doesn't save the money, for the cost of operating the Emergency Room wouldn't change if you have a few less patients. Only way to save money is if you have less hospitals. I have to take issue with a few points, I think it is key that the 50-99 groups go into the exchange, you need them to leverage the purchasing power within the overall group. If you put them all into a group like the exchange, make the exchange as big as it can ultimately be to put them all together.

Al Charbonneau: Be mindful that while we talk about administrative cost as an example, it is a cost. It doesn't add primarily to the quality of patient care. I think we need to look beyond admin.

Dr. Hittner: A comment, we have been seeing a decrease overall in emergency room use in those patients who are CurrentCare users. I also want to praise our PCPs and our FQHCs for all the work they have done to extend hours to really increase access. As we change the way we pay for things, we will see more of that.

Peter Andruskiewicz: Question for the actuaries, regarding the benchmarking. You benchmark unit cost, no surprise, you benchmark total cost by outpatient and inpatient. Did you go deeper than that? Perhaps by lab, or specialty?
Wakely: Yes, in the appendix you will see some of that, but on what is the care not, who did it. More information not in this initial report.

Ira Wilson: On the slide comparing states to each other, often we are told in RI that in Massachusetts everything costs more. What can you tell us about utilization and unit price?
Wakely: I cannot inform on this at the moment, but this is helpful point to consider.
Ira Wilson: If, for example, Massachusetts has utilization that is lower than ours, then we can do better, because it just depends on the utilization and the price tradeoff. When you present in the future, it will be helpful for us to understand how much are utilization and how much is

price.
Wakely: Absolutely, we will get to those in the summaries. Thank you.

Dale Klatzker: On the disclosures slide – the managed Medicaid insurers have paid for some of the SPMI services. Was that figured in?
Wakely: Yes, for some of those sub cap data in the MCOs we did factor that in.
Dale Klatzker: Yes, you have included the cost, but in some cases excluded. We've had a schizophrenic system in the past.
Secretary Roberts: These numbers will be included with other components, so when you see the final report, you should see those concerns addresses.

Al Kurose: We have been waiting to see these numbers for a while, in the two year period the total cost of care average was just 1.1%?
Wakely: Yes, be cognizant of the degree to which population can affect these numbers. The commercial costs vs. the Medicare advantage cost is there. Look at the trend.

Al Kurose: So, if you advocate we look at the trend, we may look at those and still say is that the state we thought we were living in during those years, where total trend was down 1.1% or up 1.4%. When we see what is happening with premium, when we engage in general dialogue on how this system has been performing, when we talk about total cost of care, when I participate in those discussions it sounds like we are not doing so well, but this data seems to imply we are doing better than general inflation.

Dennis Keefe: I do think rates have come down, and that is what this is demonstrating. Also demonstrating that utilization has been flat. If the rates are down, and can really get at incentives to reduce the utilization. Everything we have been talking about – I think the data just speaks strongly about where we need to go. I speak about hospital commercial rates being down, reimbursement rates.

Al Kurose: I understand the theoretical explanation, but at some point you would think that this relative success in controlling medical cost trend would be reflected in premium relief.

Cory King: If we can speak to how the one year pharmacy trend hits on the Medicare advantage side…
Wakely: On slide 46, looking at what has been going in the trend space. Lurking underneath the 1.4 number is the big change in pharmacy that is not likely to be repeated.

Josh Miller: There was a large enrollment in Medicaid, which had an impact on those insured privately and Medicaid, and the hospitals. Does that modify the usefulness of the '12, '13 numbers, vs. numbers that we would see after increased enrollment? That was a lot of people.
Wakely: When we present Medicaid in November we will separate the populations, the RIte Care, Rhody Health Partners, etc. to see if there is a big increase in the populations, you can look at the line in and of itself to determine the answer there best.
Dr. Hittner: When you add in Medicaid these numbers will change.

Al Kurose: I would like to try to track commercial rates, commercial premium rates, during this period and after this period. I want to see if somewhere we can make some sort of correlation. We have rates going out now for '16, three more years of rates that go past this performance period, and can we not expect to take this total cost of care performance data and somehow see it reflected in the trajectory of premium rates?

Wakely: As an actuary we use data, but do adjust things to look at the future. I would be interested to see if you modify the pharmacy trend alone I wonder what the bottom line would be. Instead of a downward 8.4 but to 8.4 upward, what would the trend be there? How would that affect PBM?
Wakely: Need to consider decreased generics, need to build it up, and yes that is why we tried to separate everything out.

IV. **Public Comment**

No additional comment was offered by the public at this time.

V. Adjourn